(3) the member is no longer eligible for MassHealth.

(C) MassHealth does not notify the member if there is no change in the member's coverage type, premium payment, or premium assistance payment.

(D) If the member's coverage type changes, the start date for the new coverage type is determined as follows.

(1) If the new coverage type provides more comprehensive benefits to the member, coverage is effective as of the date of the written notice with the following exceptions.

(a) Coverage for the purchase of medical benefits under Basic is effective upon the member's enrollment with a MassHealth managed care provider.

(b) Coverage for the purchase of medical benefits under Essential is effective upon the member's enrollment in the Primary Care Clinician (PCC) Plan. MassHealth Essential members who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).

(c) Coverage for premium assistance under Basic and Essential is effective in the calendar month following the date of the written notice. MassHealth Essential members receiving premium assistance who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).

(d) Premium assistance payments under Family Assistance begin in the month of MassHealth's eligibility determination, or in the month the insurance deduction begins, whichever is later.

(2) If the new coverage type provides less comprehensive benefits to the member, coverage is effective subsequent to the member's receipt of a timely written notice in accordance with 130 CMR 610.015.

(E) If the member fails to provide a written update of his or her circumstances within ~~30~~60 days of MassHealth's request, MassHealth coverage is terminated. If the member subsequently submits a written update, MassHealth determines his or her eligibility as of the date the written update is received. If the applicant is determined eligible, the medical coverage date is established in accordance with the rules in 130 CMR 502.006.

(F) If the member fails to provide verification of information within 60 days of MassHealth's request, MassHealth coverage is terminated.

(1) Except as provided at 130 CMR 501.003(E), if required verifications are received within one year of receipt of the previous MBR or written update on a prescribed form, coverage is reinstated 10 days before receipt of the verifications unless the member is determined eligible for the purchase of medical benefits under MassHealth Basic or Essential, or premium assistance under Basic, Essential, or Family Assistance. For those members, the medical coverage date is established in accordance with the rules in 130 CMR 502.006. Coverage under Essential is also subject to the funding restrictions described at 130 CMR 505.007.

(2) If required verifications are not received within one year of receipt of the previous MBR or written update on a prescribed form, a new MBR must be completed.

(G) retroactive RSDI and SSI benefit payments; and

(H) any other income considered noncountable under Title XIX.

520.016: Long-Term Care: Treatment of Assets

130 CMR 520.016 describes the treatment of countable assets when one member of a couple is institutionalized, the post-eligibility transfer of assets, and the allowable income deductions for applicants and members who are residents of a long-term-care facility.

(A) Institutionalized Individuals. The total value of assets owned by an institutionalized single individual or by a member of an institutionalized couple must not exceed $2,000.

(B) Treatment of a Married Couple's Assets When One Spouse Is Institutionalized.

(1) Assessment.

(a) Requirement. The ~~Division~~ MassHealth agency completes an assessment of the total value of a couple's combined countable assets and computes the ~~spousal share~~community spouse's asset allowance as of the date of the beginning of the most recent continuous period of institutionalization of one spouse.

(b) Right to Request an Assessment. When one spouse has entered a medical institution and is expected to remain institutionalized for at least 30 days, either spouse may request the ~~Division~~ MassHealth agency to make this assessment, even if the institutionalized spouse is not applying for MassHealth Standard at that time. The period of institutionalization must be continuous and expected to last for at least 30 days.

(c) Right to Appeal. The ~~Division~~ MassHealth agency must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or eligibility representative) applies for MassHealth Standard.

(2) Determination of Eligibility for the Institutionalized Spouse. At the time that the institutionalized spouse applies for MassHealth Standard, the ~~Division~~ MassHealth agency must determine the couple's current total countable assets, regardless of the form of ownership as between the couple, and the amount of assets allowed for the community spouse as follows.

(a) Deduct the community spouse's asset allowance, based on countable assets as of the date of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse, from the current combined total countable assets. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for MassHealth Standard. The community spouse's asset allowance is the greatest of the following amounts: